Cahaba Valley Surgical Group, PC

Bariatric Surgery Inquiry Form

Today's Date:	
How did you hear about us?	

Name:		Cell:	
Address:		Other Phone:	
City/ST/ZIP:		DOB:	
		SSN (last 4):	
Email:			

➢ **Patient's current Height _____ Weight _____ Body Mass Index (BMI) _____**

Pertinent Medical History (Check as appropriate)

☐Obstructive sleep apnea (☐w ☐W/O CPAP)

☐ Hypertension (#medications 1 2 3 4)

☐ Type II Diabetes (☐ oral meds ☐ insulin)

☐ Osteoarthritis or other musculoskeletal condition

☐ Heart Disease (any surgeries, stents)

☐ Other weight-related conditions (list)

_____

_____

Previous Surgical History

☐ Nissen fundoplication

☐ Gastric bypass

☐ Gastric band

☐ Gastric sleeve

☐ Other GI surgery

_____

Attended a weight-loss seminar? Y N

Do you have a referring doctor?	☐Yes ☐No	
Do you have a primary care physician (if different)?	☐Yes ☐No	

INSURANCE INFORMATION: Please fax a <u>legible</u> copy of ALL Insurance cards, front and back

Primary Insurance:	Subscriber Name:
Policy No.	Subscriber DOB:
Group No.	

Notes:	